

AMENDED IN ASSEMBLY APRIL 27, 2010

AMENDED IN ASSEMBLY APRIL 5, 2010

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL

No. 2244

Introduced by Assembly Member Feuer

February 18, 2010

An act to add Article 11.7 (commencing with Section 1399.825) to Chapter 2.2 of Division 2 of the Health and Safety Code, and to add Chapter 9.7 (commencing with Section 10950) to Part 2 of Division 2 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2244, as amended, Feuer. Health care coverage.

Existing law provides for the licensing and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes a health care service plan or health insurer to exclude an applicant from coverage for a specified time for preexisting conditions. A willful violation of provisions governing health care service plans is a crime.

This bill would require all health care service plans and insurance carriers that offer health care coverage to children or individuals to offer that coverage, by specified dates, to any child or individual seeking coverage. The bill would also prohibit, by specified dates, the exclusion or limitation of coverage due to any preexisting condition. The bill would further establish and require the implementation of standard risk rates with respect to plan contracts or health benefit plans that provide coverage to children, as specified. The bill would authorize the

Department of Managed Health Care and the Department of Insurance to adopt emergency regulations for purposes of implementation.

By imposing new requirements on health care service plans, the willful violation of which would be a crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Article 11.7 (commencing with Section 1399.825)
2 is added to Chapter 2.2 of Division 2 of the Health and Safety
3 Code, to read:

4
5 Article 11.7. Individual Access to Health Care
6

7 1399.825. As used in this article:

8 (a) (1) “Child” means any individual under 19 years of age.

9 (2) “Responsible party for a child” means an adult having
10 custody of a child with the right to make medical decisions for,
11 and with the responsibility for the financial needs of, the child.

12 (b) “Individual” means any individual over 19 years of age.

13 (c) “In force business” means an existing health benefit plan
14 contract issued by the plan to an individual.

15 ~~(e)~~

16 (d) “New business” means a health care service plan contract
17 issued to an individual that is not the plan’s in force business.

18 ~~(f)~~

19 (e) “Preexisting condition provision” means a contract provision
20 that excludes coverage for charges or expenses incurred during a
21 specified period following the individual’s effective date of
22 coverage, as to a condition for which medical advice, diagnosis,
23 care, or treatment was recommended or received during a specified
24 period immediately preceding the effective date of coverage.

25 ~~(g)~~

1 (f) "Rating period" means the period for which premium rates
2 established by a plan are in effect and shall be no less than 12
3 months.

4 ~~(h)~~

5 (g) "Risk adjusted individual risk rate" means the rate
6 determined for an eligible individual or child in a particular risk
7 category after applying the risk adjustment factor.

8 ~~(i)~~

9 (h) "Risk adjustment factor" means the percentage adjustment
10 to be applied equally to each standard risk rate for a particular
11 child, based upon any expected deviations from standard cost of
12 services. This factor may not be more than 120 percent or less than
13 80 percent until January 1, 2012. Effective January 1, 2012, this
14 factor may not be more than 110 percent or less than 90 percent.
15 Effective January 1, 2014, the standard risk rate shall apply to all
16 policies sold to individuals or for children.

17 ~~(j)~~

18 (i) "Risk category" means the following characteristics of an
19 eligible child: age, geographic region, and family composition of
20 the individual, plus the health benefit plan selected by the
21 individual.

22 (1) Until January 1, 2014, no more than the following age
23 categories may be used in determining premium rates:

24 (A) Under age 5.

25 (B) Age 5-15.

26 (C) Age 15-19.

27 (2) The rate shall not vary by more than 2 to 1 for children.

28 (3) Individual health care service plans shall base rates for
29 individuals and children using no more than the following family
30 size categories:

31 (A) Single.

32 (B) Married couple.

33 (C) One adult and child or children.

34 (D) Married couple and child or children.

35 (4) In determining rates for individuals and children, a plan that
36 operates statewide shall use the geographic regions specified in
37 Section 1357.

38 ~~(k)~~

1 (j) Nothing in this section shall be construed to require a plan
2 to establish a new service area or to offer health coverage on a
3 statewide basis, outside of the plan's existing service area.

4 1399.826. (a) (1) Effective January 1, 2011, every health care
5 service plan offering plan contracts for children shall offer coverage
6 to the responsible party for any child that seeks coverage.

7 (2) Effective January 1, 2014, every health care service plan
8 offering plan contracts to individuals shall offer coverage to any
9 individual who seeks coverage.

10 (b) (1) Effective January 1, 2011, notwithstanding any other
11 provision of state law or regulation, every health care service plan
12 offering contracts for children shall not exclude or limit coverage
13 due to any preexisting condition.

14 (2) Effective January 1, 2014, notwithstanding any other
15 provision of state law or regulation, every health care service plan
16 offering contracts for ~~children~~ *individuals* shall not exclude or
17 limit coverage due to any preexisting condition.

18 (c) This article shall not apply to coverage to which an employer
19 makes any contribution.

20 (d) Every health care service plan offering plan contracts to
21 individuals shall in addition to complying with the provisions of
22 this chapter and the rules adopted thereunder comply with the
23 provisions of this article.

24 1399.827. This article shall not apply to health plan contracts
25 for coverage of Medicare services pursuant to contracts with the
26 United States government, Medicare supplement, Medi-Cal
27 contracts with the State Department of Health *Care* Services,
28 Healthy Families, long-term care coverage, or specialized health
29 plan contracts.

30 1399.828. (a) Upon the effective date of this article, a health
31 care service plan shall fairly and affirmatively offer, market, and
32 sell all of the plan's health care service plan contracts that are
33 offered and sold to the responsible party for a child. Effective
34 January 1, 2014, a health care service plan shall fairly and
35 affirmatively offer, market, and sell all of the plan's health care
36 service plan contracts that are sold to individuals.

37 (b) Effective January 1, 2011, a health care service plan shall
38 not reject an application from the responsible party for a child for
39 a health care service plan contract. Effective January 1, 2014, a

1 health care service plan shall not reject an application from an
2 individual for a health care service plan contract.

3 (c) No health care service plan or solicitor shall, directly or
4 indirectly, engage in the following activities:

5 (1) Encourage or direct an individual or responsible party for a
6 child to refrain from filing an application for coverage with a plan
7 because of the health status, claims experience, industry,
8 occupation of the individual or child, or geographic location
9 provided that it is within the plan's approved service area.

10 (2) Encourage or direct individuals or children to seek coverage
11 from another plan because of the health status, claims experience,
12 industry, occupation of the individual or child, or geographic
13 location, provided that it is within the plan's approved service area.

14 (d) A health care service plan shall not, directly or indirectly,
15 enter into any contract, agreement, or arrangement with a solicitor
16 that provides for or results in the compensation paid to a solicitor
17 for the sale of a health care service plan contract to be varied
18 because of the health status, claims experience, industry,
19 occupation, or geographic location of the individual or child. This
20 subdivision does not apply to a compensation arrangement that
21 provides compensation to a solicitor on the basis of percentage of
22 premium, provided that the percentage shall not vary because of
23 the health status, claims experience, industry, occupation, or
24 geographic area of the individual or child.

25 (e) Effective January 1, 2011, a health care service plan contract
26 that covers a child shall not establish rules for eligibility, including
27 continued eligibility, of an individual, or dependent of an
28 individual, to enroll under the terms of the plan based on any of
29 the following health status-related factors:

30 (1) Health status.

31 (2) Medical condition, including physical and mental illnesses.

32 (3) Claims experience.

33 (4) Receipt of health care.

34 (5) Medical history.

35 (6) Genetic information.

36 (7) Evidence of insurability, including conditions arising out of
37 acts of domestic violence.

38 (8) Disability.

39 (9) Any other health status-related factor determined appropriate
40 by department.

1 ~~(f) A health care service plan shall comply with the requirements~~
2 ~~of Section 1374.3.~~

3 ~~(g) Effective January 1, 2014, this section shall apply to all~~
4 ~~individuals and children obtaining coverage with no contribution~~
5 ~~from an employer.~~

6 1399.829. (a) After an individual or the responsible party for
7 a child submits a completed application form for a plan contract,
8 the health care service plan shall, within 30 days, notify the
9 individual or responsible party for a child of actual premium
10 charges for that plan contract established in accordance with
11 Section 1399.836. The individual or responsible party for a child
12 shall have 30 days in which to exercise the right to buy coverage
13 at the quoted premium charges.

14 (b) When an individual or the responsible party for a child
15 submits a premium payment, based on the quoted premium charges,
16 and that payment is delivered or postmarked, whichever occurs
17 earlier, within the first 15 days of the month, coverage under the
18 plan contract shall become effective no later than the first day of
19 the following month. When that payment is neither delivered nor
20 postmarked until after the 15th day of a month, coverage shall
21 become effective no later than the first day of the second month
22 following delivery or postmark of the payment.

23 (c) During the first 60 days after the effective date of the plan
24 contract, the individual or responsible party for a child shall have
25 the option of changing coverage to a different plan contract offered
26 by the same health care service plan. If an individual or the
27 responsible party for a child notifies the plan of the change within
28 the first 15 days of a month, coverage under the new plan contract
29 shall become effective no later than the first day of the following
30 month. If an individual or the responsible party for a child notifies
31 the plan of the change after the 15th day of a month, coverage
32 under the new plan contract shall become effective no later than
33 the first day of the second month following notification.

34 1399.830. (a) Effective January 1, 2011, a health care service
35 plan may not exclude any child who would otherwise be entitled
36 to health care services on the basis of an actual or expected health
37 condition of that child. No health care service plan contract may
38 limit or exclude coverage for a child by type of illness, treatment,
39 medical condition, or accident.

1 (b) Effective January 1, 2014, a health care service plan may
2 not exclude any individual who would otherwise be entitled to
3 health care services on the basis of an actual or expected health
4 condition of that individual. No health care service plan contract
5 may limit or exclude coverage for a child by type of illness,
6 treatment, medical condition, or accident.

7 1399.831. All health care service plan contracts offered to an
8 individual or child shall provide to subscribers and enrollees at
9 least all of the basic health care services in this act.

10 1399.832. No health care service plan shall be required to offer
11 a health care service plan contract or accept applications for the
12 contract pursuant to this article in the case of any of the following:

13 (a) To an individual or child, if the individual or child who is
14 to be covered by the plan contract does not work or reside within
15 the plan's approved service areas.

16 (b) (1) Within a specific service area or portion of a service
17 area, if the plan reasonably anticipates and demonstrates to the
18 satisfaction of the director that it will not have sufficient health
19 care delivery resources to ensure that health care services will be
20 available and accessible to the individual or child because of its
21 obligations to existing enrollees.

22 (2) A health care service plan that cannot offer a health care
23 service plan contract to individuals or children because it is lacking
24 in sufficient health care delivery resources within a service area
25 or a portion of a service area may not offer a contract in the area
26 in which the plan is not offering coverage to individuals to new
27 employer groups until the plan notifies the director that it has the
28 ability to deliver services to individuals, and certifies to the director
29 that from the date of the notice it will enroll all individuals
30 requesting coverage in that area from the plan ~~unless the plan has~~
31 ~~met the requirements of subdivision (d).~~

32 (3) Nothing in this article shall be construed to limit the
33 director's authority to develop and implement a plan of
34 rehabilitation for a health care service plan whose financial viability
35 or organizational and administrative capacity has become impaired.

36 ~~(e) Offer coverage to an individual or child that, within 12~~
37 ~~months of application for coverage, disenrolled from a plan contract~~
38 ~~offered by the plan.~~

39 ~~(d) (1) The director approves the plan's certification that the~~
40 ~~number of eligible employees and dependents enrolled under~~

1 contracts issued during the current calendar year equals or exceeds
2 either of the following:

3 (A) In the case of a plan that administers any self-funded health
4 coverage arrangements in California, 10 percent of the total
5 enrollment of the plan in California as of December 31 of the
6 preceding year.

7 (B) In the case of a plan that does not administer any self-funded
8 health coverage arrangements in California, 8 percent of the total
9 enrollment of the plan in California as of December 31 of the
10 preceding year. If that certification is approved, the plan shall not
11 offer any health benefit plan to any small employers during the
12 remainder of the current year.

13 (2) If a health care service plan treats an affiliate or subsidiary
14 as a separate carrier for the purpose of this article because one
15 health care service plan is qualified under the federal Health
16 Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) and
17 does not offer coverage to small employers, while the affiliate or
18 subsidiary offers a plan contract that is not qualified under the
19 federal Health Maintenance Organization Act (42 U.S.C. Sec. 300e
20 et seq.) and offers plan contracts to small employers, the health
21 care service plan offering coverage to small employers shall enroll
22 new eligible employees and dependents, equal to the applicable
23 percentage of the total enrollment of both the health care service
24 plan qualified under the federal Health Maintenance Organization
25 Act (42 U.S.C. Sec. 300e et seq.) and its affiliate or subsidiary.

26 (3) (A) The certified statement filed pursuant to this subdivision
27 shall state the following:

28 (i) Whether the plan administers any self-funded health coverage
29 arrangements in California.

30 (ii) The plan's total enrollment as of December 31 of the
31 preceding year.

32 (iii) The number of eligible employees and dependents enrolled
33 under contracts issued to small employer groups during the current
34 calendar year.

35 (B) The director shall, within 45 days, approve or disapprove
36 the certified statement. If the certified statement is disapproved,
37 the plan shall continue to issue coverage as required by Section
38 1357.03 and be subject to disciplinary action as set forth in Article
39 7 (commencing with Section 1386).

1 1399.833. The director may require a health care service plan
2 to discontinue the offering of contracts or acceptance of
3 applications from any individual or child upon a determination by
4 the director that the plan does not have sufficient financial viability
5 or organizational and administrative capacity to ensure the delivery
6 of health care services to its enrollees. In determining whether the
7 conditions of this section have been met, the director shall consider,
8 but not be limited to, the plan's compliance with the requirements
9 of Section 1367, Article 6 (commencing with Section 1375.1), and
10 the rules adopted under those provisions.

11 1399.834. All health care service plan contracts offered to a
12 child or individual shall be renewable at the option of the enrollee
13 or responsible party for a child except:

14 (a) For nonpayment of the required premiums by the enrollee
15 or responsible party for a child.

16 (b) For fraud or misrepresentation by the individuals or their
17 representatives.

18 (c) When the health care service plan ceases to provide or
19 arrange for the provision of health care services for new individual
20 health care service plan contracts in this state; provided, however,
21 that the following conditions are satisfied:

22 (1) Notice of the decision to cease new or existing individual
23 health benefits plans in this state is provided to the director and to
24 the contractholder at least 360 days prior to the discontinuation of
25 the coverage.

26 (2) Individual health care service plan contracts subject to this
27 article shall not be canceled for 360 days after the date of the notice
28 required under paragraph (1) and for that business of a plan which
29 remains in force, any plan that ceases to offer for sale new
30 individual health care service plan contracts shall continue to be
31 governed by this article with respect to business conducted under
32 this article.

33 (3) Except as authorized under ~~subdivision (d) of Section~~
34 ~~1399.832 or~~ Section 1399.833, a plan that ceases to write new
35 individual business in this state after the effective date of this article
36 shall be prohibited from offering for sale new individual health
37 care service plan contracts in this state for a period of five years
38 from the date of notice to the director.

39 (d) When the health care service plan withdraws a health care
40 service plan contract from the individual market; provided, the

1 plan notifies all affected contractholders and the director at least
2 180 days prior to the discontinuation of those contracts, and the
3 plan makes available to the individual all plan contracts that it
4 makes available to new individual business; and provided, that the
5 premium for the new plan contract complies with the renewal
6 increase requirements set forth in Section 1399.836.

7 1399.836. Effective January 1, 2011, premiums for contracts
8 offered or delivered by health care service plans on or after the
9 effective date of this article for children shall be subject to the
10 following requirements:

11 (a) The premium for new business shall be determined for an
12 eligible child in a particular risk category after applying a risk
13 adjustment factor to the plan's standard risk rates. The risk adjusted
14 risk rate may not be more than 120 percent or less than 80 percent
15 of the plan's applicable standard risk rate until January 1, 2012.
16 Effective January 1, 2012, this factor may not be more than 110
17 percent or less than 90 percent. The standard risk rates applied to
18 a child for new business shall be in effect for no less than 12
19 months.

20 (b) (1) The premium for in force business shall be determined
21 for an eligible child in a particular risk category after applying a
22 risk adjustment factor to the plan's standard individual risk rates.
23 The risk adjusted individual risk rates may not be more than 120
24 percent or less than 80 percent of the plan's applicable standard
25 risk rate until January 1, 2011. Effective January 1, 2012, this
26 factor may not be more than 110 percent or less than 90 percent.
27 The factor effective January 1, 2011, shall apply to in force
28 business at the earlier of either the time of renewal or January 1,
29 2012. The risk adjustment factor applied to a child may not increase
30 by more than 10 percentage points from the risk adjustment factor
31 applied in the prior rating period. The risk adjustment factor for a
32 child may not be modified more frequently than once every 12
33 months.

34 (2) The standard risk rates shall be in effect for no less than 12
35 months.

36 (3) For a contract that a plan has discontinued offering, the risk
37 adjustment factor applied to the standard risk rates for the first
38 rating period of the new contract that the responsible party for the
39 child elects to purchase shall be no greater than the risk adjustment
40 factor applied in the prior rating period to the discontinued contract.

1 However, the risk adjusted individual risk rate may not be more
2 than 120 percent or less than 80 percent of the plan's applicable
3 standard risk rate until January 1, 2012. Effective January 1, 2012,
4 this factor may not be more than 110 percent or less than 90
5 percent. The factor effective January 1, 2012, shall apply to in
6 force business at the earlier of either the time of renewal or January
7 1, 2012. The risk adjustment factor for a child may not be modified
8 more frequently than once every 12 months.

9 1399.837. Health care service plans shall apply standard risk
10 rates consistently with respect to all children.

11 1399.838. In connection with the offering for sale of any plan
12 contract for children, each plan shall make a reasonable disclosure,
13 as part of its solicitation and sales materials, of the following:

14 (a) The extent to which premium rates for a specific child are
15 established or adjusted in part based upon the actual or expected
16 variation in service costs or actual or expected variation in health
17 condition of the child.

18 (b) The provisions concerning the plan's right to change
19 premium rates and the factors, other than provision of services
20 experience, that affect changes in premium rates.

21 (c) Provisions relating to the guaranteed issue and renewal of
22 contracts.

23 (d) Provisions relating to the child's right to apply for any
24 contract written, issued, or administered by the plan at the time of
25 application for a new health care service plan contract, or at the
26 time of renewal of a health care service plan contract.

27 (e) The availability, upon request, of a listing of all the plan's
28 contracts and benefit plan designs offered for children, including
29 the rates for each contract.

30 (f) At the time it offers a contract to the responsible party for a
31 child, each plan shall provide the responsible party with a statement
32 of all of its plan contracts offered to children, including the rates
33 for each plan contract, in the service area in which the individuals
34 who are to be covered by the plan contract reside. For purposes of
35 this subdivision, plans that are affiliated plans or that are eligible
36 to file a consolidated income tax return shall be treated as one
37 health plan.

38 (g) Each health care service plan shall do all of the following:

39 (1) Prepare a brochure that summarizes all of its plan contracts
40 offered to children and to make this summary available to any

1 responsible party for a child and to solicitors upon request. The
2 summary shall include for each contract information on benefits
3 provided, a generic description of the manner in which services
4 are provided, such as how access to providers is limited, benefit
5 limitations, required copayments and deductibles, standard risk
6 rates, and a phone number that can be called for more detailed
7 benefit information. Plans are required to keep the information
8 contained in the brochure accurate and up to date and, upon
9 updating the brochure, send copies to solicitors and solicitor firms
10 with whom the plan contracts to solicit enrollments or
11 subscriptions.

12 (2) For each contract, prepare a more detailed evidence of
13 coverage and make it available to responsible parties, solicitors,
14 and solicitor firms upon request. The evidence of coverage shall
15 contain all information that a prudent buyer would need to be aware
16 of in making contract selections.

17 (3) Provide to responsible parties and solicitors, upon request,
18 for any given child the standard risk rates. When requesting this
19 information, responsible parties, solicitors, and solicitor firms shall
20 provide the plan with the information the plan needs to determine
21 the individual's risk adjusted risk rate.

22 (4) Provide copies of the current summary brochure to all
23 solicitors and solicitor firms contracting with the plan to solicit
24 enrollments or subscriptions from responsible parties for children.

25 For purposes of this subdivision, plans that are affiliated plans
26 or that are eligible to file a consolidated income tax return shall
27 be treated as one health plan.

28 (h) Every solicitor or solicitor firm contracting with one or more
29 plans to solicit enrollments or subscriptions from responsible
30 parties for children shall do all of the following:

31 (1) When providing information on contracts to a responsible
32 party for a child or children but making no specific
33 recommendations on particular plan contracts:

34 (A) Advise the responsible party of the plan's obligation to sell
35 to any responsible party any plan contract it offers for children
36 and provide them, upon request, with the actual rates that would
37 be charged for that child for a given contract.

38 (B) Notify the responsible party that the solicitor or solicitor
39 firm will procure rate and benefit information for the responsible

1 party for the child on any plan contract offered by a plan whose
2 contract the solicitor sells.

3 (C) Notify the responsible party that upon request the solicitor
4 or solicitor firm will provide the responsible party with the
5 summary brochure required under this paragraph for any plan
6 contract offered by a plan with whom the solicitor or solicitor firm
7 has contracted to solicit enrollments or subscriptions.

8 (2) When recommending a particular benefit plan design or
9 designs, advise the responsible party that, upon request, the agent
10 will provide the responsible party with the brochure required by
11 paragraph (1) containing the benefit plan design or designs being
12 recommended by the agent or broker.

13 (3) Prior to filing an application for a responsible party for a
14 child for a particular contract:

15 (A) For each of the plan contracts offered by the plan whose
16 contract the solicitor or solicitor firm is offering, provide the
17 responsible party with the benefit summary required in paragraph
18 (1) and the standard risk rates for that particular child.

19 (B) Notify the responsible party that, upon request, the solicitor
20 or solicitor firm will provide the responsible party with an evidence
21 of coverage brochure for each contract the plan offers.

22 (C) Notify the responsible party for a child that, from January
23 1, 2011, to January 1, 2012, actual rates may be 20 percent higher
24 or lower than the standard risk rates, and from January 1, 2012,
25 until December 31, 2014, actual rates may be 10 percent higher
26 or lower than the standard risk rates, depending on how the plan
27 assesses the risk of the child.

28 (D) Notify the responsible party that, upon request, the solicitor
29 or solicitor firm will submit information to the plan to ascertain
30 the child's risk adjusted risk rate for any contract the plan offers.

31 (E) Obtain a signed statement from the responsible party
32 acknowledging that the responsible party has received the
33 disclosures required by this section.

34 1399.839. (a) At least 30 business days prior to renewing or
35 amending a plan contract subject to this article that will be in force
36 on the operative date of this article, a plan shall file a notice of
37 material modification with the director in accordance with the
38 provisions of Section 1352. The notice of material modification
39 shall include a statement certifying that the plan is in compliance
40 with subdivision ~~(j)~~ (i) of Section 1399.825 and Section 1399.836.

1 The certified statement shall set forth the standard risk rate for
2 each risk category and the highest and lowest risk adjustment
3 factors that will be used in setting the rates at which the contract
4 will be renewed or amended. Any action by the director, as
5 permitted under Section 1352, to disapprove, suspend, or postpone
6 the plan's use of a plan contract shall be in writing, specifying the
7 reasons that the plan contract is not in compliance with the
8 requirements of this chapter.

9 (b) At least 30 business days prior to offering a plan contract
10 subject to this article, all plans shall file a notice of material
11 modification with the director in accordance with the provisions
12 of Section 1352. The notice of material modification shall include
13 a statement certifying that the plan is in compliance with
14 subdivision-~~(j)~~ (i) of Section 1399.825 and Section 1399.836. The
15 certified statement shall set forth the standard risk rate for each
16 risk category and the highest and lowest risk adjustment factors
17 that will be used in setting the rates at which the contract will be
18 offered. Plans that will be offering to a responsible party for a child
19 contracts approved by the director prior to the effective date of
20 this article shall file a notice of material modification in accordance
21 with this subdivision. Any action by the director, as permitted
22 under Section 1352, to disapprove, suspend, or postpone the plan's
23 use of a plan contract shall be in writing, specifying the reasons
24 that the plan contract is not in compliance with the requirements
25 of this chapter.

26 (c) Prior to making any changes in the risk categories, risk
27 adjustment factors, or standard risk rates filed with the director
28 pursuant to subdivision (a) or (b), the plan shall file, as an
29 amendment, a statement setting forth the changes and certifying
30 that the plan is in compliance with subdivision-~~(j)~~ (i) of Section
31 1399.825 and Section 1399.836. A plan may commence offering
32 plan contracts utilizing the changed risk categories set forth in the
33 certified statement on the 45th day from the date of the filing, or
34 at an earlier time determined by the director, unless the director
35 disapproves the amendment by written notice, stating the reasons
36 therefor. If only the standard risk rate is being changed, and not
37 the risk categories or risk adjustment factors, a plan may commence
38 offering plan contracts utilizing the changed standard risk rate
39 upon the 31st day after filing the certified statement unless the
40 director disapproves the amendment by written notice.

1 (d) Periodic changes to the standard risk rate that a plan proposes
2 to implement over the course of up to 12 consecutive months may
3 be filed in conjunction with the certified statement filed under
4 subdivision (a), (b), or (c).

5 (e) Each plan shall maintain at its principal place of business
6 all of the information required to be filed with the director pursuant
7 to this section.

8 (f) Each plan shall make available to the director, on request,
9 the risk adjustment factor used in determining the rate for any
10 particular child.

11 (g) Nothing in this section shall be construed to limit the
12 director's authority to enforce the rating practices set forth in this
13 article.

14 1399.840. The director may issue regulations that are necessary
15 to carry out the purposes of this article. Prior to the public comment
16 period required by regulations under the Administrative Procedure
17 Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of
18 Division 3 of Title 2 of the Government Code), the director shall
19 provide the Insurance Commissioner with a copy of the proposed
20 regulations. The Insurance Commissioner shall have 30 days to
21 notify the director in writing of any comments on the regulations.
22 The Insurance Commissioner's comments shall be included in the
23 public notice issued on the regulations. Any rules and regulations
24 adopted pursuant to this article may be adopted as emergency
25 regulations in accordance with the Administrative Procedure Act.
26 Until December 31, 2015, the adoption of these regulations shall
27 be deemed an emergency and necessary for the immediate
28 preservation of the public peace, health and safety, or general
29 welfare. Any regulations adopted prior to December 31, 2015, in
30 order to remain in effect after December 31, 2016, shall be
31 readopted as nonemergency regulations in accordance with the
32 Administrative Procedures Act prior to December 31, 2016.

33 SEC. 2. Chapter 9.7 (commencing with Section 10950) is added
34 to Part 2 of Division 2 of the Insurance Code, to read:

35
36 CHAPTER 9.7. INDIVIDUAL ACCESS TO HEALTH INSURANCE
37

38 10950. As used in this article:

39 (a) (1) "Child" means any individual under 19 years of age.

1 (2) “Responsible party for a child” means an adult having
2 custody of a child with the right to make medical decisions for,
3 and with the responsibility for the financial needs of, the child.

4 (b) “Individual” means any individual over 19 years of age.

5 (c) “In force business” means an existing health benefit plan
6 issued by a carrier to an individual.

7 ~~(e)~~

8 (d) “New business” means a health benefit plan issued to an
9 individual that is not the carrier’s in force business.

10 ~~(f)~~

11 (e) “Preexisting condition provision” means a contract provision
12 that excludes coverage for charges or expenses incurred during a
13 specified period following the individual’s effective date of
14 coverage, as to a condition for which medical advice, diagnosis,
15 care, or treatment was recommended or received during a specified
16 period immediately preceding the effective date of coverage.

17 ~~(g)~~

18 (f) “Rating period” means the period for which premium rates
19 established by a carrier are in effect and shall be no less than 12
20 months.

21 ~~(h)~~

22 (g) “Risk adjusted individual risk rate” means the rate
23 determined for an eligible individual or child in a particular risk
24 category after applying the risk adjustment factor.

25 ~~(i)~~

26 (h) “Risk adjustment factor” means the percentage adjustment
27 to be applied equally to each standard risk rate for a particular
28 child, based upon any expected deviations from standard cost of
29 services. This factor may not be more than 120 percent or less than
30 80 percent until January 1, 2012. Effective January 1, 2012, this
31 factor may not be more than 110 percent or less than 90 percent.
32 Effective January 1, 2014, the standard risk rate shall apply to all
33 policies sold to individuals or for children.

34 ~~(j)~~

35 (i) “Risk category” means the following characteristics of an
36 eligible child: age, geographic region, and family composition of
37 the individual, plus the health benefit plan selected by the
38 individual.

39 (1) Until January 1, 2014, no more than the following age
40 categories may be used in determining premium rates:

1 (A) Under age 5.

2 (B) Age 5-15.

3 (C) Age 15-19.

4 (2) The rate shall not vary by more than 2 to 1 for children.

5 (3) Carriers shall base rates for individuals and children using
6 no more than the following family size categories:

7 (A) Single.

8 (B) Married couple.

9 (C) One adult and child or children.

10 (D) Married couple and child or children.

11 (4) In determining rates for individuals and children, a carrier
12 that operates statewide shall the geographic regions specified in
13 Section 10700.

14 ~~(k)~~

15 (j) Nothing in this section shall be construed to require a carrier
16 to establish a new service area or to offer health coverage on a
17 statewide basis, outside of the carrier's existing service area.

18 10951. (a) (1) Effective January 1, 2011, every carrier offering
19 health benefit plans for children shall offer coverage to the
20 responsible party for any child that seeks coverage.

21 (2) Effective January 1, 2014, every carrier offering health
22 benefit plans to individuals shall offer coverage to any individual
23 who seeks coverage.

24 (b) (1) Effective January 1, 2011, notwithstanding any other
25 provision of state law or regulation, every carrier offering contracts
26 for children shall not exclude or limit coverage due to any
27 preexisting condition.

28 (2) Effective January 1, 2014, notwithstanding any other
29 provision of state law or regulation, every carrier offering contracts
30 for ~~children~~ *individuals* shall not exclude or limit coverage due to
31 any preexisting condition.

32 (c) This article shall not apply to coverage to which an employer
33 makes any contribution.

34 (d) Every carrier offering health benefit plans to individuals
35 shall in addition to complying with the provisions of this chapter
36 and the rules adopted thereunder comply with the provisions of
37 this article.

38 10952. This article shall not apply to health benefit plans for
39 coverage of Medicare services pursuant to contracts with the United
40 States government, Medicare supplement, Medi-Cal contracts with

1 the State Department of Health *Care* Services, Healthy Families,
2 long-term care coverage, or specialized health benefit plans.

3 10953. (a) Upon the effective date of this article, a carrier shall
4 fairly and affirmatively offer, market, and sell all of the carrier's
5 contracts that are offered and sold to the responsible party for a
6 child. Effective January 1, 2014, a carrier shall fairly and
7 affirmatively offer, market, and sell all of the carrier's contracts
8 that are sold to individuals.

9 (b) Effective January 1, 2011, a carrier shall not reject an
10 application from the responsible party for a child for a health
11 benefit plan. Effective January 1, 2014, a carrier shall not reject
12 an application from an individual for a health benefit plan.

13 (c) No carrier or solicitor shall, directly or indirectly, engage in
14 the following activities:

15 (1) Encourage or direct an individual or responsible party for a
16 child to refrain from filing an application for coverage with a carrier
17 because of the health status, claims experience, industry,
18 occupation of the individual or child, or geographic location
19 provided that it is within the carrier's approved service area.

20 (2) Encourage or direct individuals or children to seek coverage
21 from another carrier because of the health status, claims experience,
22 industry, occupation of the individual or child, or geographic
23 location, provided that it is within the carrier's approved service
24 area.

25 (d) A carrier shall not, directly or indirectly, enter into any
26 contract, agreement, or arrangement with a solicitor that provides
27 for or results in the compensation paid to a solicitor for the sale of
28 a health benefit plan to be varied because of the health status,
29 claims experience, industry, occupation, or geographic location
30 of the individual or child. This subdivision does not apply to a
31 compensation arrangement that provides compensation to a
32 solicitor on the basis of percentage of premium, provided that the
33 percentage shall not vary because of the health status, claims
34 experience, industry, occupation, or geographic area of the
35 individual or child.

36 (e) Effective January 1, 2011, a health care service health benefit
37 plan that covers a child shall not establish rules for eligibility,
38 including continued eligibility, of an individual, or dependent of
39 an individual, to enroll under the terms of the carrier based on any
40 of the following health status-related factors:

- 1 (1) Health status.
- 2 (2) Medical condition, including physical and mental illnesses.
- 3 (3) Claims experience.
- 4 (4) Receipt of health care.
- 5 (5) Medical history.
- 6 (6) Genetic information.
- 7 (7) Evidence of insurability, including conditions arising out of
- 8 acts of domestic violence.
- 9 (8) Disability.
- 10 (9) Any other health status-related factor determined appropriate
- 11 by department.

12 (f) A carrier shall comply with the requirements of subdivision

13 (c) of Section 10119.

14 (g) Effective January 1, 2014, this section shall apply to all

15 individuals and children obtaining coverage with no contribution

16 from an employer.

17 10954. (a) After an individual or the responsible party for a

18 child submits a completed application form for a health benefit

19 plan, the carrier shall, within 30 days, notify the individual or

20 responsible party for a child of actual premium charges for that

21 health benefit plan established in accordance with Section 10960.

22 The individual or responsible party for a child shall have 30 days

23 in which to exercise the right to buy coverage at the quoted

24 premium charges.

25 (b) When an individual or the responsible party for a child

26 submits a premium payment, based on the quoted premium charges,

27 and that payment is delivered or postmarked, whichever occurs

28 earlier, within the first 15 days of the month, coverage under the

29 health benefit plan shall become effective no later than the first

30 day of the following month. When that payment is neither delivered

31 nor postmarked until after the 15th day of a month, coverage shall

32 become effective no later than the first day of the second month

33 following delivery or postmark of the payment.

34 (c) During the first 60 days after the effective date of the health

35 benefit plan, the individual or responsible party for a child shall

36 have the option of changing coverage to a different health benefit

37 plan offered by the same carrier. If an individual or the responsible

38 party for a child notifies the carrier of the change within the first

39 15 days of a month, coverage under the new health benefit plan

40 shall become effective no later than the first day of the following

1 month. If an individual or the responsible party for a child notifies the carrier of the change after the 15th day of a month, coverage under the new health benefit plan shall become effective no later than the first day of the second month following notification.

10955. (a) Effective January 1, 2011, a carrier may not exclude any child who would otherwise be entitled to health care services on the basis of an actual or expected health condition of that child. No health care service health benefit plan may limit or exclude coverage for a child by type of illness, treatment, medical condition, or accident.

(b) Effective January 1, 2014, a carrier may not exclude any individual who would otherwise be entitled to health care services on the basis of an actual or expected health condition of that individual. No health care service health benefit plan may limit or exclude coverage for a child by type of illness, treatment, medical condition, or accident.

10956. All health benefit plans offered to an individual or child shall provide to contractholders and insureds at least all of the basic health care services in this act.

10957. No carrier shall be required to offer a health benefit plan or accept applications for the contract pursuant to this article in the case of any of the following:

(a) To an individual or child, if the individual or child who is to be covered by the health benefit plan does not work or reside within the carrier's approved service areas.

(b) (1) Within a specific service area or portion of a service area, if the carrier reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have sufficient health care delivery resources to ensure that health care services will be available and accessible to the individual or child because of its obligations to existing insureds.

(2) A carrier that cannot offer a health benefit plan to individuals or children because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area may not offer a contract in the area in which the carrier is not offering coverage to individuals to new employer groups until the carrier notifies the commissioner that it has the ability to deliver services to individuals, and certifies to the commissioner that from the date of the notice it will enroll all individuals requesting coverage in

1 that area from the carrier unless the carrier has met the requirements
2 of subdivision (d).

3 (3) Nothing in this article shall be construed to limit the
4 commissioner's authority to develop and implement a plan of
5 rehabilitation for a carrier whose financial viability or
6 organizational and administrative capacity has become impaired.

7 ~~(e) Offer coverage to an individual or child that, within 12~~
8 ~~months of application for coverage, disenrolled from a health~~
9 ~~benefit plan offered by the carrier.~~

10 ~~(d) (1) The commissioner approves the carrier's certification~~
11 ~~that the number of eligible employees and dependents enrolled~~
12 ~~under contracts issued during the current calendar year equals or~~
13 ~~exceeds either of the following:~~

14 ~~(A) In the case of a carrier that administers any self-funded~~
15 ~~health coverage arrangements in California, 10 percent of the total~~
16 ~~enrollment of the carrier in California as of December 31 of the~~
17 ~~preceding year.~~

18 ~~(B) In the case of a carrier that does not administer any~~
19 ~~self-funded health coverage arrangements in California, 8 percent~~
20 ~~of the total enrollment of the carrier in California as of December~~
21 ~~31 of the preceding year. If that certification is approved, the carrier~~
22 ~~shall not offer any health benefit plan to any small employers~~
23 ~~during the remainder of the current year.~~

24 ~~(2) If a carrier treats an affiliate or subsidiary as a separate~~
25 ~~carrier for the purpose of this article because one carrier is qualified~~
26 ~~under the federal Health Maintenance Organization Act (42 U.S.C.~~
27 ~~Sec. 300e et seq.) and does not offer coverage to small employers,~~
28 ~~while the affiliate or subsidiary offers a plan contract that is not~~
29 ~~qualified under the federal Health Maintenance Organization Act~~
30 ~~(42 U.S.C. Sec. 300e et seq.) and offers health benefit plans to~~
31 ~~small employers, the carrier offering coverage to small employers~~
32 ~~shall enroll new eligible employees and dependents, equal to the~~
33 ~~applicable percentage of the total enrollment of both the carrier~~
34 ~~qualified under the federal Health Maintenance Organization Act~~
35 ~~(42 U.S.C. Sec. 300e et seq.) and its affiliate or subsidiary.~~

36 ~~(3) (A) The certified statement filed pursuant to this subdivision~~
37 ~~shall state the following:~~

38 ~~(i) Whether the carrier administers any self-funded health~~
39 ~~coverage arrangements in California.~~

1 ~~(ii) The carrier's total enrollment as of December 31 of the~~
2 ~~preceding year.~~

3 ~~(iii) The number of eligible employees and dependents enrolled~~
4 ~~under health benefit plans issued to small employer groups during~~
5 ~~the current calendar year.~~

6 ~~(B) The commissioner shall, within 45 days, approve or~~
7 ~~disapprove the certified statement. If the certified statement is~~
8 ~~disapproved, the carrier shall continue to issue coverage and be~~
9 ~~subject to disciplinary action.~~

10 10958. The commissioner may require a carrier to discontinue
11 the offering of contracts or acceptance of applications from any
12 individual or child upon a determination by the commissioner that
13 the carrier does not have sufficient financial viability or
14 organizational and administrative capacity to ensure the delivery
15 of health care services to its insureds. In determining whether the
16 conditions of this section have been met, the commissioner shall
17 consider, but not be limited to, the carrier's compliance with the
18 requirements of this part and the rules adopted under those
19 provisions.

20 10959. All health benefit plans offered to a child or individual
21 shall be renewable at the option of the insured or responsible party
22 for a child except:

23 (a) For nonpayment of the required premiums by the insured or
24 responsible party for a child.

25 (b) For fraud or misrepresentation by the individuals or their
26 representatives.

27 (c) When the carrier ceases to provide or arrange for the
28 provision of health care services for new individual health benefit
29 plans in this state; provided, however, that the following conditions
30 are satisfied:

31 (1) Notice of the decision to cease new or existing individual
32 health benefits plans in this state is provided to the commissioner
33 and to the contractholder at least 360 days prior to the
34 discontinuation of the coverage.

35 (2) Individual health benefit plans subject to this article shall
36 not be canceled for 360 days after the date of the notice required
37 under paragraph (1) and for that business of a carrier which remains
38 in force, any carrier that ceases to offer for sale new individual
39 health benefit plans shall continue to be governed by this article
40 with respect to business conducted under this article.

1 (3) Except as authorized under ~~subdivision (d) of Section 10957~~
2 ~~or~~ Section 10959, a carrier that ceases to write new individual
3 business in this state after the effective date of this article shall be
4 prohibited from offering for sale new individual health benefit
5 plans in this state for a period of five years from the date of notice
6 to the commissioner.

7 (d) When the carrier withdraws a health benefit plan from the
8 individual market; provided, the carrier notifies all affected
9 contractholders and the commissioner at least 180 days prior to
10 the discontinuation of those contracts, and the carrier makes
11 available to the individual all health benefit plans that it makes
12 available to new individual business; and provided, that the
13 premium for the new health benefit plan complies with the renewal
14 increase requirements set forth in Section 10960.

15 10960. Effective January 1, 2011, premiums for contracts
16 offered or delivered by carriers on or after the effective date of
17 this article for children shall be subject to the following
18 requirements:

19 (a) The premium for new business shall be determined for an
20 eligible child in a particular risk category after applying a risk
21 adjustment factor to the carrier's standard risk rates. The risk
22 adjusted risk rate may not be more than 120 percent or less than
23 80 percent of the carrier's applicable standard risk rate until January
24 1, 2012. Effective January 1, 2012, this factor may not be more
25 than 110 percent or less than 90 percent. The standard risk rates
26 applied to a child for new business shall be in effect for no less
27 than 12 months.

28 (b) (1) The premium for in force business shall be determined
29 for an eligible child in a particular risk category after applying a
30 risk adjustment factor to the carrier's standard individual risk rates.
31 The risk adjusted individual risk rates may not be more than 120
32 percent or less than 80 percent of the carrier's applicable standard
33 risk rate until January 1, 2011. Effective January 1, 2012, this
34 factor may not be more than 110 percent or less than 90 percent.
35 The factor effective January 1, 2011, shall apply to in force
36 business at the earlier of either the time of renewal or January 1,
37 2012. The risk adjustment factor applied to a child may not increase
38 by more than 10 percentage points from the risk adjustment factor
39 applied in the prior rating period. The risk adjustment factor for a

1 child may not be modified more frequently than once every 12
2 months.

3 (2) The standard risk rates shall be in effect for no less than 12
4 months.

5 (3) For a contract that a carrier has discontinued offering, the
6 risk adjustment factor applied to the standard risk rates for the first
7 rating period of the new contract that the responsible party for the
8 child elects to purchase shall be no greater than the risk adjustment
9 factor applied in the prior rating period to the discontinued contract.
10 However, the risk adjusted individual risk rate may not be more
11 than 120 percent or less than 80 percent of the carrier's applicable
12 standard risk rate until January 1, 2012. Effective January 1, 2012,
13 this factor may not be more than 110 percent or less than 90
14 percent. The factor effective January 1, 2012, shall apply to in
15 force business at the earlier of either the time of renewal or January
16 1, 2012. The risk adjustment factor for a child may not be modified
17 more frequently than once every 12 months.

18 10961. Carriers shall apply standard risk rates consistently with
19 respect to all children.

20 10962. In connection with the offering for sale of any health
21 benefit plan for children, each carrier shall make a reasonable
22 disclosure, as part of its solicitation and sales materials, of the
23 following:

24 (a) The extent to which premium rates for a specific child are
25 established or adjusted in part based upon the actual or expected
26 variation in service costs or actual or expected variation in health
27 condition of the child.

28 (b) The provisions concerning the carrier's right to change
29 premium rates and the factors, other than provision of services
30 experience, that affect changes in premium rates.

31 (c) Provisions relating to the guaranteed issue and renewal of
32 contracts.

33 (d) Provisions relating to the child's right to apply for any
34 contract written, issued, or administered by the carrier at the time
35 of application for a new health benefit plan, or at the time of
36 renewal of a health benefit plan.

37 (e) The availability, upon request, of a listing of all the plan's
38 contracts and benefit plan designs offered for children, including
39 the rates for each contract.

(f) At the time it offers a contract to the responsible party for a child, each carrier shall provide the responsible party with a statement of all of its health benefit plans offered to children, including the rates for each health benefit plan, in the service area in which the individuals who are to be covered by the health benefit plan reside. For purposes of this subdivision, carriers that are affiliated carriers or that are eligible to file a consolidated income tax return shall be treated as one carrier.

(g) Each carrier shall do all of the following:

(1) Prepare a brochure that summarizes all of its health benefit plans offered to children and to make this summary available to any responsible party for a child and to solicitors upon request. The summary shall include for each contract information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, standard risk rates, and a phone number that can be called for more detailed benefit information. carriers are required to keep the information contained in the brochure accurate and up to date and, upon updating the brochure, send copies to solicitors and solicitor firms with whom the health benefit plans to solicit enrollments or subscriptions.

(2) For each contract, prepare a more detailed evidence of coverage and make it available to responsible parties, solicitors, and solicitor firms upon request. The evidence of coverage shall contain all information that a prudent buyer would need to be aware of in making contract selections.

(3) Provide to responsible parties and solicitors, upon request, for any given child the standard risk rates. When requesting this information, responsible parties, solicitors, and solicitor firms shall provide the carrier with the information the carrier needs to determine the individual's risk adjusted risk rate.

(4) Provide copies of the current summary brochure to all solicitors and solicitor firms contracting with the carrier to solicit enrollments or subscriptions from responsible parties for children.

For purposes of this subdivision, carriers that are affiliated carriers or that are eligible to file a consolidated income tax return shall be treated as one carrier.

1 (h) Every solicitor or solicitor firm contracting with one or more
2 carriers to solicit enrollments or subscriptions from responsible
3 parties for children shall do all of the following:

4 (1) When providing information on contracts to a responsible
5 party for a child or children but making no specific
6 recommendations on particular health benefit plans:

7 (A) Advise the responsible party of the carrier's obligation to
8 sell to any responsible party any health benefit plan it offers for
9 children and provide them, upon request, with the actual rates that
10 would be charged for that child for a given contract.

11 (B) Notify the responsible party that the solicitor or solicitor
12 firm will procure rate and benefit information for the responsible
13 party for the child on any health benefit plan offered by a carrier
14 whose contract the solicitor sells.

15 (C) Notify the responsible party that upon request the solicitor
16 or solicitor firm will provide the responsible party with the
17 summary brochure required under this paragraph for any health
18 benefit plan offered by a carrier with whom the solicitor or solicitor
19 firm has contracted to solicit enrollments or subscriptions.

20 (2) When recommending a particular benefit plan design or
21 designs, advise the responsible party that, upon request, the agent
22 will provide the responsible party with the brochure required by
23 paragraph (1) containing the benefit plan design or designs being
24 recommended by the agent or broker.

25 (3) Prior to filing an application for a responsible party for a
26 child for a particular contract:

27 (A) For each of the health benefit plans offered by the carrier
28 whose contract the solicitor or solicitor firm is offering, provide
29 the responsible party with the benefit summary required in
30 paragraph (1) and the standard risk rates for that particular child.

31 (B) Notify the responsible party that, upon request, the solicitor
32 or solicitor firm will provide the responsible party with an evidence
33 of coverage brochure for each contract the carrier offers.

34 (C) Notify the responsible party for a child that, from January
35 1, 2011, to January 1, 2012, actual rates may be 20 percent higher
36 or lower than the standard risk rates, and from January 1, 2012,
37 until December 31, 2014, actual rates may be 10 percent higher
38 or lower than the standard risk rates, depending on how the carrier
39 assesses the risk of the child.

1 (D) Notify the responsible party that, upon request, the solicitor
2 or solicitor firm will submit information to the carrier to ascertain
3 the child's the risk adjusted risk rate for any contract the carrier
4 offers.

5 (E) Obtain a signed statement from the responsible party
6 acknowledging that the responsible party has received the
7 disclosures required by this section.

8 10963. (a) At least 30 business days prior to renewing or
9 amending a health benefit plan subject to this article that will be
10 in force on the operative date of this article, a carrier shall file a
11 notice of material modification with the commissioner. The notice
12 of material modification shall include a statement certifying that
13 the carrier is in compliance with subdivision~~(j)~~ (i) of Section 10950
14 and Section 10960. The certified statement shall set forth the
15 standard risk rate for each risk category and the highest and lowest
16 risk adjustment factors that will be used in setting the rates at which
17 the contract will be renewed or amended. Any action by the
18 commissioner to disapprove, suspend or postpone the carrier's use
19 of a health benefit plan shall be in writing, specifying the reasons
20 that the health benefit plan is not in compliance with the
21 requirements of this chapter.

22 (b) At least 30 business days prior to offering a health benefit
23 plan subject to this article, all carriers shall file a notice of material
24 modification with the commissioner. The notice of material
25 modification shall include a statement certifying that the carrier
26 is in compliance with subdivision~~(j)~~ (i) of Section 10950 and
27 Section 10960. The certified statement shall set forth the standard
28 risk rate for each risk category and the highest and lowest risk
29 adjustment factors that will be used in setting the rates at which
30 the contract will be offered. Carriers that will be offering to a
31 responsible party for a child contracts approved by the
32 commissioner prior to the effective date of this article shall file a
33 notice of material modification in accordance with this subdivision.
34 Any action by the commissioner to disapprove, suspend, or
35 postpone the carrier's use of a health benefit plan shall be in
36 writing, specifying the reasons that the health benefit plan is not
37 in compliance with the requirements of this chapter.

38 (c) Prior to making any changes in the risk categories, risk
39 adjustment factors or standard risk rates filed with the
40 commissioner pursuant to subdivision (a) or (b), the carrier shall

1 file, as an amendment, a statement setting forth the changes and
2 certifying that the carrier is in compliance with subdivision ~~(j)~~ (i)
3 of Section 10950 and Section 10960. A carrier may commence
4 offering health benefit plans utilizing the changed risk categories
5 set forth in the certified statement on the 45th day from the date
6 of the filing, or at an earlier time determined by the commissioner,
7 unless the commissioner disapproves the amendment by written
8 notice, stating the reasons therefor. If only the standard risk rate
9 is being changed, and not the risk categories or risk adjustment
10 factors, a carrier may commence offering health benefit plans
11 utilizing the changed standard risk rate upon the 31st day after
12 filing the certified statement unless the commissioner disapproves
13 the amendment by written notice.

14 (d) Periodic changes to the standard risk rate that a carrier
15 proposes to implement over the course of up to 12 consecutive
16 months may be filed in conjunction with the certified statement
17 filed under subdivision (a), (b), or (c).

18 (e) Each carrier shall maintain at its principal place of business
19 all of the information required to be filed with the commissioner
20 pursuant to this section.

21 (f) Each carrier shall make available to the commissioner, on
22 request, the risk adjustment factor used in determining the rate for
23 any particular child.

24 (g) Nothing in this section shall be construed to limit the
25 commissioner's authority to enforce the rating practices set forth
26 in this article.

27 10964. The commissioner may issue regulations that are
28 necessary to carry out the purposes of this article. Prior to the
29 public comment period required by regulations under the
30 Administrative Procedure Act (Chapter 3.5 (commencing with
31 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
32 Code), the commissioner shall provide the Director of Managed
33 Health Care with a copy of the proposed regulations. The director
34 shall have 30 days to notify the commissioner in writing of any
35 comments on the regulations. The director's comments shall be
36 included in the public notice issued on the regulations. Any rules
37 and regulations adopted pursuant to this article may be adopted as
38 emergency regulations in accordance with the Administrative
39 Procedure Act. Until December 31, 2015, the adoption of these
40 regulations shall be deemed an emergency and necessary for the

1 immediate preservation of the public peace, health and safety, or
2 general welfare. Any regulations adopted prior to December 31,
3 2015, in order to remain in effect after December 31, 2016, shall
4 be readopted as nonemergency regulations in accordance with the
5 Administrative Procedures Act prior to December 31, 2016.

6 SEC. 3. No reimbursement is required by this act pursuant to
7 Section 6 of Article XIII B of the California Constitution because
8 the only costs that may be incurred by a local agency or school
9 district will be incurred because this act creates a new crime or
10 infraction, eliminates a crime or infraction, or changes the penalty
11 for a crime or infraction, within the meaning of Section 17556 of
12 the Government Code, or changes the definition of a crime within
13 the meaning of Section 6 of Article XIII B of the California
14 Constitution.

15
16
17 CORRECTIONS:

18 Text—Page 23.
19